CHILD MEDICAL CARE AUTHORIZATION

This is to acknowledge that ____
is authorized to obtain whatever medical attention is necessary should my child
_____________________ be injured while in their custody.

Insurance Information:

Insurance Carrier	____________________________
Policy No.	____________________________
Group No.	____________________________
Phone No.	____________________________

Medical Information:

Doctor ___________________________ Phone _________________________
Dentist __________________________ Phone _________________________

Known Allergies/Allergic Reactions:

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_________________________________ ______________________________
(Signature) **(Date)**